Case Number:	CM13-0038272		
Date Assigned:	12/18/2013	**Date of Injury:**	05/17/2011
Decision Date:	04/18/2014	**UR Denial Date:**	09/13/2013
Priority:	Standard	**Application Received:**	09/30/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a Physician Reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The Physician Reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Management, and is licensed to practice in Georgia. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The Physician Reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The claimant is a 49-year-old presenting with low back and left hip, left knee, and left ankle pain following a work-related injury on July 8, 2013. The claimant complains of pain in the left knee and low back with radiation to the left thigh. The physical exam was significant for tenderness over the medial and lateral joint lines. X-rays on July 18, 2013 were negative for any acute abnormalities. The claimant was diagnosed with lumbosacral spine strain, and the sacral spine contusion, and left hip strain. The claimant tried physical therapy and medications including Relafen 750 mg, Flexeril 10 mg, Prednisone 20 mg, knee brace, and TENS unit.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

SHOCKWAVE THERAPY 1 TIME PER WEEK FOR 6 WEEKS FOR TREATMENT OF THE RIGHT KNEE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG),Knee Chapter: Extracorporeal shock wave therapy (ESWT).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Section Low Back Pain, Treatment Consideration.

Decision rationale: Shockwave therapy 1 time per week for 6 weeks for treatment of the right knee is not medically necessary. The ODG guidelines indicate that shockwave treatment is not recommended in the treatment of low back pain. Extracorporeal shockwave therapy is considered experimental and investigational for numerous conditions, including low back pain. The employee failed to improve with medication and physical therapy; therefore the request is not medically necessary.